Mount Sinai
MEDICAL CENTER

June 17, 2019

Linda D. Smith
Associate Regional Administrator
Division of Survey & Certification
Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street SW, Suite 4T20
Atlanta, Georgia 30303-8909

RE: CMS Certification Number (CCN) 10-0034

Dear Ms. Smith,

We are in receipt of your correspondence dated June 10, 2019 outlining the results of the survey that was conducted at Mount Sinai Medical Center on June 4, 2019.

Enclosed you will find the Action Plan we have developed in order to correct the deficiencies found in the COPs for 42 CFR 482.12 Governing Body, 42 CFR 482.13 Patient Rights, and 42 CFR 482.21 QAPI.

We look forward to receiving your approval of this Action Plan. If you have any questions or require any further information please contact Cathy McClellan at 305-674-2555.

Thank you for your consideration in this matter.

Sincerely,

Steven D. Sonenreich
President and Chief Executive Officer
Mount Sinai Medical Center

cc: Arlene Mayo-Davis
Field Office Manager
8333 NW 53rd St. Suite 200
Miami, Florida 33166

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100034	A. BUILDING _____ B. WING _____	C 06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT SINAI MEDICAL CENTER	4300 ALTON RD MIAMI BEACH, FL 33140

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A 000	INITIAL COMMENTS An unannounced federal complaint survey, complaint number: 2019008293, was conducted on 05/29/2019 to 05/30/2019 and 06/04/2019 at Mount Sinai Medical Center, which is located at 4300 Alton Road, Miami, FL. 33140 to review the Conditions of Participation: Patient Rights, Governing Body and Quality Assessment Performance Improvement (QAPI). Mount Sinai Medical Center was not in compliance with the Federal Regulations at 42 CFR 482 requirements for Acute Care Hospitals. Immediate Jeopardy was identified on 05/29/2019 and ongoing at the Condition of Participation: Patient Rights A-115. Condition level deficiencies were identified at: QAPI A-263, and Governing Body A-43.	A 000	A-043 CFR(s): 482.12 The Professional Affairs Committee (PAC) of the Board of Trustees of the Medical Center will provide oversight and accountability to ensure that patient rights are protected, a safe environment is maintained, clear expectations for patient safety are set and an effective Quality and Performance Improvement program is in place. The PAC is compromised of several members of the Governing Board, Hospital CEO, Chief of Staff, Medical Staff Leadership, Chief Nursing Officer, Chief Medical Office, Senior Vice President of Special Services, and Vice President of Quality. The PAC meets monthly and reports its activities to the full Hospital Governing Board. The plan for improving the processes that lead to the deficiencies cited includes how the hospital is addressing improvements in its systems, in order to prevent the likelihood of recurrence of the deficient practice. It was identified that the hospital had multiple conflicting policies that required review, feedback and updates. The following policies will be reviewed by PAC on the next scheduled meeting (6/18/19) as part of the overall action plan presented by the VP of Risk Management: Abuse, Neglect or Exploitation Policy – renamed to Required Reporting of Allegations/ Possible Abuse, Neglect or Abandonment of Patients. This Hospital wide policy defines the steps taken to report abuse, neglect or abandonment attributed to either internal or external events. There is now clear expectation that the appropriate reporting bodies will be contacted, such as DCF if abuse is suspected or has occurred. If the allegation involves a hospital employee and a patient, the involved employee will be removed from all patient contact until the investigation is conducted. The Sexual Assault Protocol (RAPE) – policy has been expanded to a Hospital Wide Policy and now reflects a section on how to care for a patient after an alleged sexual assault, which includes but is not limited to, the Nursing Supervisor or Charge Nurse assigning a 1:1 Patient Safety Tech or Sitter to the patient. The Patient Safety Tech or Sitter assigned to the patient will be the gender of the patients choice. The accused employee will be immediately removed from the area of the allegation and will not be able to return to work until cleared pending Human Resources determination.	6/17/19
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on record reviews, staff interviews, and review of policies, the governing body failed to maintain responsibility for the conduct of the hospital employees and ensure the effectiveness of the person(s) responsible for the conduct of the hospital employees resulting in an incident of sexual assault involving one patient (SP #1) of 4	A 043		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cathy J. McClellan — TITLE: VP, Risk Management & PI — (X6) DATE: 6-17-19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 043	Continued From page 1 sampled patients (SP). (Refer to A-0057)	A 043	Continued from page 1	
A 057	CHIEF EXECUTIVE OFFICER CFR(s): 482.12(b) The governing body must appoint a chief executive officer who is responsible for managing the hospital. This STANDARD is not met as evidenced by: Based on record review, staff interviews and review of policies the governing body failed to maintain responsibility for ensure the effectiveness of person(s) responsible for the conduct of the hospital employees resulting in an incident of sexual assault involving one patient (SP #1) of 4 sampled patients (SP). Findings include: Clinical Record review of sample patient (SP) #1, revealed she arrived in the ER (Emergency Room) on 11/05/2019 at 10:22 PM. She was Baker Acted on 11/06/2018 at 12:01PM for recurrent major depressive disorder/suicidal ideation. She was admitted to the Behavioral Health Unit on 11/06/2018 at 11:00 AM. Review of Behavioral Health Nursing Notes of the Primary Nurse/Staff-D, documented on 11/07/2018 at 11:32 PM that at 7:40 PM patient approaches registered nurse on duty to complain that she has been sexually harassed by emergency room mental health technician in her room 474. Charge nurse and attending psychiatrist made aware. Police notified. Evidence collected by law enforcement for analysis. Patient was to be transported to rape trauma center at [named] Hospital for evaluation	A 057	During Shift Hand-Off, staff will communicate the wishes of the patient should they request minimal or no exposure to a particular gender while under 1:1. Behavioral Health General Safety Policy was revised to further explain the expectations of staff when not in direct patient care. The Policy stresses the importance of intervening if they witness actions that did not follow policy and the consequences associated with not following the policy. The Allegations of Sexual Misconduct and Police Investigations – Human Resource Policy was created to provide an internal procedure for reporting of allegations of sexual misconduct perpetuated by an employee and the process that will be followed regarding the subject of such allegations. At the conclusion of the investigation, Risk Management and Human Resources will review the results with the Senior VP/VP of the affected department and the CNO or CMO (as appropriate) and a decision will be made regarding whether to reinstate the employee and/or take disciplinary action. A final report of the investigation results and the actions taken will be reported to the CEO. If an employee is reinstated prior to completion of a police investigation, the report shall document the justification for such reinstatement as determined by Human Resources. Mandatory comprehensive Sexual Abuse Education was completed by clinical staff which clarified the process regarding allegations. There were no exceptions for completion except for staff that were on a leave of absence. If the staff member was not scheduled to work, they could not return until completion of the education. Nursing Administration held a huddle with Nursing Leaders to explain the process of reporting and what their role is when an allegation is brought to their attention.	6/13/19 6/17/19 6/17/19 6/14/19

Cathy J. McClellan VP, Risk Mgmt/PI 6-17-19

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A 057	Continued From page 2 as recommended by law enforcement. In an interview with Vice President Risk Management on 05/29/2019 at 11:07AM revealed on 11/05/2018, patient complained of being sexually assaulted by a Mental Health Technician (MHT) and identified employee by name. The police were called and conducted an investigation. Arrangements were made to transfer patient with 2-MHT employees to the Rape Treatment Center to be evaluated. At some point, the police interviewed the employee and obtained DNA specimen from him. Investigation was conducted by Risk Management, Human Resources and the Behavioral Health Nursing Director, all whom spoke with employee. Employee indicated that he was in the room only minutes. Last Wednesday, 05/22/2019, the hospital administration was informed that the DNA sample taken from the patient matched the DNA taken from the employee and the employee was arrested. The following day, Thursday, 05/23/2019, the Vice President Risk Management and the Director Risk Management notified the Joint Commission but did not notify the Department of Children's and Families. The DNA findings were consistent with the police report, on the breast and the in the vagina. The actual results were not provided to the facility. Interview with Clinical Director Behavioral Health on 05/29/2019 at 3:02PM revealed the employee Staff A attended a 1-day training on 05/22/2019 and went to police station. This was the last day of work for the employee. The Clinical Director Behavioral Health had a staff meeting on 11/15/2018, to discuss mandatory education on abuse and neglect and remind staff about not entering patient rooms alone. Review of	A 057	Continue from page 2 **Quality Monitoring and accountability for A-043 CFR(s): 482.12** 1.) Policies listed above were approved by PAC, uploaded to Policy Stat, rolled out to staff and changes were communicated via Policy Memo from the Chief Compliance Officer. 2.) A Risk Management log was created to validate compliance of daily reporting. Director of RM will monitor Nursing Supervisor Report in order to complete the log on a daily basis. The log will include verification of the following: notification of the CEO by the VP of RM, notifying DCF, notifying the Police and documentation of DCF notification in the medical record. 3.) BH monitoring log to validate Q15 checks. This monitoring will be accomplished by doing unannounced spot-check visual rounding and by monitoring the camera surveillance in the nursing station real-time. This will be done by Director of BH. 4.) VP of RM will present Lessons Learned at PAC as a result of the RCA. In addition, results of Quality Monitoring will be presented on a monthly basis until completion of the action plan. 5.) Education compliance of the BH General Safety Policy will be 100% as exhibited through the sign-in sheet by 6/17/19. Evidence of compliance will be submitted to the PI department by June 17, 2019. A weekly report will be submitted to the PI department to show evidence of completion for those employees who were not scheduled during the roll out of this education. This was rolled out by the Director of BH. 6.) Education compliance of the Sexual Abuse education will be 90% compliance as exhibited by the NetLearning electronic report by 6/17/19. Of those employees not scheduled during the roll-out of this education, all employees will complete the course before resuming patient care. This is done by the Manager of Training and Development. Evidence of compliance will be submitted to the PI department by 6/17/19. A weekly report will be submitted to the PI department to show evidence of completion for those employees who were not scheduled during the roll out of this education. 7.) Compliance of the New Employee education will be documented by the Manager of Training and Development. 100% compliance will be exhibited by signed check lists submitted to the Quality Manager. 8.) Purposeful Rounding education will be documented by the Director of Behavioral Health. 100% compliance will be exhibited by sign-in sheet provided to the PI Department.	

Cathy J. McClellan VP, RM & PI 6-17-19

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A 057	Continued From page 3 Behavioral Health General Staff Meeting Agenda documented on 11/15/2018 revealed Findings/Conclusions: Only enter patient room alone when doing rounds or quickly completing duties/tasks. Do not have 1:1 conversations alone in room, this is regardless of gender. This is the best way to protect yourself from allegations and possible physical violence. Recommendations/Action: Longer conversations or 1:1 support should be given in hallway or dining rooms (anywhere on camera). Any longer activity, get second staff. No students or Non-behavioral health staff to be left alone with patients. Accompany them to rooms. Review of Department of Psychiatry/Behavioral Health Sign-in sheet revealed approximately 51 signatures out of approximately 86 staff members in attendance. No policy was written or corrective action plan was implemented after the incident. Interview with Clinical Director Behavioral Health on 06/04/2019 at 11:03AM revealed the incident has not been presented to the Board but the report is in draft to be presented at the next meeting.	A 057	Continued from page 3 9.) Director of Risk Management will audit the reporting process outlined in policy for all allegations of sexual misconduct. This audit will assure that the appropriate 1:1 observation was assigned, that the accused employee was suspended/removed, DCF was called and the Police were notified. Four months of data will be submitted to the Quality Manager to show evidence of 100% compliance. A-057 CFR(s) 482.12(b) The Chief Executive Officer appointed by the Governing Body is responsible for ensuring the effectiveness of person(s) responsible for the conduct of hospital employees. The CEO provides oversight and accountability to ensure that patient rights are protected, a safe environment is maintained, set clear expectations for patient safety and an effective Quality and Performance Improvement program is in place. The CEO has been in constant communication on all aspects of the action taken to immediately correct the deficiencies and has approved all of the action plans for improving the processes that lead to the deficiencies cited. The CEO will ensure the Polices reviewed by PAC will be implemented. The Allegations of Sexual Misconduct and Police Investigations policy now states that a final report of the investigation results and the actions taken will be reported to the CEO by the VP of Risk Management. I An email sent to clinical staff stressing the	6/17/19
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on record review, staff interviews, and review of policies, the facility failed to provide care in a safe setting, and ensure the patient's right to be free from all forms of (sexual) abuse in 1 (SP #1) out of 4 sample patients (SP). The hospital's failure to prevent abuse resulted in an	A 115	importance of timely completion of the mandatory comprehensive Sexual Abuse Education was sent out by the CEO. All clinical staff are expected to complete the training, with no exceptions, unless the employees were on a leave of absence. Staff that did not complete the education could not resume patient care until they have completed the course. **Quality Monitoring and Accountability for A-057 CFR(s) 482.12 (b):** 1.) Policies listed above were approved by PAC, uploaded to Policy Stat, rolled out to staff and changes were communicated via Policy Memo from the Chief Compliance Officer. 2.) VP of Risk will present Lessons Learned at PAC as a result of the RCA. In addition, results of Quality Monitoring as outlined in this plan will be presented on a monthly basis until completion of the action plan.	6/13/19 6/17/19

Cathy J. McClellan VP, Risk Mgmt & PI 6-17-19

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A 115	Continued From page 4 employee sexually assaulting a patient. The hospital's failure to ensure patients are free from abuse, sexual assault by employees providing care and services resulted in a findings of immediate jeopardy beginning on 05/29/2019 and ongoing, creating a situation that is likely to result in serious injury, harm, impairment, or death to patients and requires immediate corrective action on the part of the hospital. (Refer to A-0144 and A-0145)	A 115	Continue from page 4 The Behavioral Health General Safety Policy was revised to be more specific regarding protocols for entering patient rooms. Staff was educated on the revised policy. The education and training stressed the importance of intervening if they witness actions by other staff that did not follow policy. The education and training also included the consequences associated with not following the policy. Human Resources has developed a policy to delineate the process for employees who are under investigation by law enforcement. Employees under police investigation will be reviewed by the Service Line Vice President, CNO, CMO (as appropriate) and a member of Human Resources to make a joint decision on the appropriateness of the employee returning to work. A final report of the actions taken will be reported to the CEO by the VP of Risk Management. In addition to Sexual Abuse Education as described in this CAP, it has been added to New Employee Orientation. The orientation checklist for New Employee Orientation was revised to validate that staff understand the definition of abuse, duty to report and professional behavior that is expected. The Behavioral Health Charge Nurse will ensure that all staff present on the unit are the appropriate/necessary staff for the shift. Staff not assigned to the unit will be not be allowed onto the floor unless performing assigned duties requiring their presence. **Quality Monitoring and Accountability for A-115, CFR(s): 482.13** 1.) A Risk Management log was created to validate compliance of daily reporting. Director of RM will monitor Nursing Supervisor Report in order to complete the log on a daily basis. The log will include verification of the following: notification of the CEO by the VP of Risk Management, notifying DCF, notifying the Police and documentation of DCF notification in the medical record. 2.) BH created a monitoring log to validate Q15 checks. This monitoring will be accomplished by doing unannounced spot-check visual rounding and by monitoring the camera surveillance in the nursing station real-time. This will be done by Director of BH. 3.) VP of Risk will present Lessons Learned at PAC as a result of the RCA. In addition, results of Quality Monitoring as outlined in this plan will be presented on a monthly basis until completion of the action plan.	6/13/19 6/17/19 6/14/19
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on record review, staff interviews, and review of policies, the facility failed to provide care in a safe setting, in 1 (SP #1) out of 4 sample patients (SP). The hospital's failure to ensure the employee provide care and services in a safe setting resulted in a findings of immediate jeopardy beginning on 05/29/2019 and ongoing, creating a situation that is likely to result in serious injury, harm, impairment, or death to patients and requires immediate correction action on the part of the hospital. The findings include: Review of Behavioral Health Nursing Notes of the (Primary Nurse) Staff-D, documented on 11/07/2018 at 11:32 PM that at 7:40 PM patient approaches registered nurse on duty to complain that she has been sexually harassed by emergency room mental health technician in her room 474. Charge nurse and attending psychiatrist made aware. Police notified.	A 144		

Cathy J. McClellan VP, Risk Mgmt/PI 6-17-19

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A 144	Continued From page 5 Evidence collected by law enforcement for analysis. Patient arranges to be transported to rape trauma center at [named] Hospital for evaluation as recommended by law enforcement. In an interview with (Primary Nurse) Staff-D via telephone on 05/29/2019 at 3:25 PM revealed that nurse was in the hallway when the patient was yelling and mentioned that the Spanish guy raped me. Review of Staff-A Disciplinary Action documented on 11/15/2018 that Reason: failure to follow protocol. On Wednesday, November 7, 2018, employee had 1:1 conversation with patient in room with no other staff present. Patient later made allegations against staff member, and due to the break in protocol (no other staff members present, interaction no captured on camera), police had to be called to conduct investigation into patient allegations. Police investigated patient allegations, and cleared staff of any wrongdoing. The escalation of this issue could have been avoided if employee had followed protocol. Employee was suspended unpaid on Thursday, 11/08/2018 for one day and received written counseling signed 11/19/2018. In an interview with Clinical Director Behavioral Health Unit on 05/29/2019 at 12:41PM revealed that unless the staff is doing every 15 minute rounding or 1:1, despite gender, at any time in the room they should have a witness (another staff member) with them. The employee returned to direct patient care in the behavioral health department (to include the inpatient unit and the emergency department psyche area) pending the results of the DNA	A 144	Continued from page 5 4.) Education compliance of the Behavioral Health General Safety Policy will be 100% compliance as exhibited through the sign-in sheet by June 17, 2019. Evidence of compliance will be submitted to the PI department by June 17, 2019. A weekly report will be submitted to the PI department to show evidence of completion for those employees who were not scheduled during the roll out of this education. This was rolled out by the Director of BH. 5.) Education compliance of the Sexual Abuse education will be 90% compliance as exhibited by the NetLearning electronic report by June 17, 2019. Of those employees not scheduled during the roll-out of this education, all employees will complete the course before resuming patient care. This is done by the Manager of Training and Development. Evidence of compliance will be submitted to the PI department by June 17, 2019. A weekly report will be submitted to the PI department to show evidence of completion for those employees who were not scheduled during the roll out of this education 6.) Compliance of the New Employee education will be documented by the Manager of Training and Development. 100% compliance will be exhibited by signed check lists submitted to the Quality Manager. 7.) Purposeful Rounding education will be documented by the Director of Behavioral Health. 100% compliance will be exhibited by sign-in sheet provided to the PI Department. 8.)Director of Risk Management will audit the reporting process outlined in policy for all allegations of sexual misconduct. This audit will assure that the appropriate 1:1 observation was assigned, that the accused employee was suspended/removed, DCF was called and the Police were notified. Four months of data will be submitted to the Quality Manager to show evidence of 100% compliance. A-144 CFR(s):482.13(c)(2) The Emergency Department Sexual Assault Protocol (Rape) has been revised and adapted as an organization-wide policy. The policy was updated to include a section on how to care for a patient who states they are a victim of sexual assault which includes, but is not limited to, the Nursing Supervisor or Charge Nurse assigning	6/17/19

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A 144	Continued From page 6 sample. Review of clock punches for period 11/01/2018 - 11/30/2018 revealed patient worked Wednesday, 11/07/2018, (date of incident). Employee was suspended unpaid on Thursday, 11/08/2018, and returned to regular work schedule on Friday, 11/09/2018. The facility's administration was notified on 05/22/2019 that the DNA sample taken from the patient matched the DNA taken from the employee and the employee was issued a termination letter on 05/23/2019. Interview with Behavioral Health Unit Director on 05/29/2019 at 3:02PM revealed employee was assigned to psyche intake unit in the ED. In this role, the tech assisted with admission documentation and transported patients from the ED to the inpatient psyche unit and if it is not busy in the ED, staff is asked to help in the inpatient unit. The Behavioral Health policy with the title: "Suspected Patient Abuse/Neglect, 16.4.021," (revised date: 05/2019) states all patients admitted to the Department of Psychiatry/Behavioral Health Unit shall be protected from abuse of any kind including physical roughness, verbal threats or harassment,. DEFINITION: SEXUAL ABUSE - Sexual abuse includes any sexual overture made to a patient verbal or physical irrespective of patient's willingness to be involved in it.	A 144	Continue from page 6 1:1 Patient Safety Tech or Sitter to the Patient. The Patient Safety Tech or Sitter assigned to the Patient will be the gender of the patients choice. If it is alleged against an employee, accused employee will be immediately removed from the area of the allegation and will not be able to return to work until cleared pending Human Resources determination. The education stressed the importance of intervening if they witness employees actions that did not follow policy and the consequences associated with not following the policy. HR has developed a policy to delineate the process for employees who are under investigation by police. Employees under police investigation will be reviewed by the he Service Line Vice President, CNO, CMO (as appropriate) and a member of HR to make a joint decision on the appropriateness of the employee returning to work. A final report of the actions taken will be reported to the CEO by the VP of RM. The Sexual Abuse Education has been added to New Employee Orientation. The orientation checklist f was revised to validate that staff understand the definition of abuse, duty to report and professional behavior that is expected. **Quality Monitoring for A-144 CFR(s):482.13(c)(2)** 1.) BH created a monitoring log to validate Q15 checks. This monitoring will be accomplished by doing unannounced spot-check visual rounding and by monitoring the camera surveillance in the nursing station real-time. This will be done by Director of BH. 2.) Education compliance of the Sexual Abuse education will be 90% compliance as exhibited by the NetLearning electronic report by 6/17/19. Of those employees not scheduled during the roll-out of this education, all employees will complete the course before resuming patient care. This is done by the Manager of Training and Development. Evidence of compliance will be submitted to the PI department by 6/17/19. A weekly report will be submitted to the PI department to show evidence of completion for those employees who were not scheduled during the roll out of this education. 3.) Purposeful Rounding education will be documented by the Director of Behavioral Health. 100% compliance will be exhibited by sign-in sheet provided to the PI Department.	6/17/19 6/14/19 6/14/19
A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3)	A 145		

Cathy J. McClellan VP, Risk Mgmt & PI 6-17-19

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A 145	Continued From page 7 The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on record review and staff interviews, and review of policies, the facility failed to ensure the patient's right to be free from all forms of (sexual) abuse in 1 (SP #1) out of 4 sample patients (SP). The hospital's failure to ensure patients are free from abuse (sexual assault) by an employee providing care and services resulted in a findings of immediate jeopardy beginning on 05/29/2019 and ongoing, creating a situation that is likely to result in serious injury, harm, impairment, or death to patients and requires immediate correction action on the part of the hospital. The findings include: The Census: on 11/07/2018, for the 3:00 PM -11:00 PM shift, was 21 patients with 8 females. Clinical Record review of sample patient (SP) #1, revealed she arrived in the ER (Emergency Room) on 11/05/2018 at 10:22 PM. She was Baker Acted on 11/06/2018 at 12:01PM for recurrent major depressive disorder/suicidal ideation. She was admitted to the Behavioral Health Unit on 11/06/2018 at 11:00 AM. Review of Behavioral Health Nursing Notes of the (Primary Nurse) Staff-D, documented on 11/07/2018 at 11:32 PM that at 7:40 PM patient approaches registered nurse on duty to complain that she has been sexually harassed by emergency room mental health technician in her room. Charge nurse and attending psychiatrist made aware. Police notified. Evidence collected	A 145	Continue from page 7 4.) Director of Risk Management will audit the reporting process outlined in policy for all allegations of sexual misconduct. This audit will assure that the appropriate 1:1 observation was assigned, that the accused employee was suspended/removed, DCF was called and the Police were notified. Four months of data will be submitted to the Quality Manager to show evidence of 100% compliance. A-145 CFR(s): 482.13(c)(3) The Emergency Department Sexual Assault Protocol (Rape) has been revised and adapted as an organization-wide policy. The policy was changed to include a section on how to care for a patient after an alleged sexual assault which includes, but is not limited to, the Nursing Supervisor or Charge Nurse assigning a 1:1 Patient Safety Tech or Sitter to the Patient. The Patient Safety Tech or Sitter assigned to the Patient will be the gender of patient choice. A Policy Memo was sent out to staff alerting them of the new changes to the policy. The accused employee will be immediately removed from the area of the allegation and will not be able to return to work until cleared pending Human Resources determination. During Shift Hand-Off, staff will communicate the wishes of the patient should they request minimal or no exposure to a particular gender while under 1:1 observation. A flag was created to confirm DCF reporting was completed when a sexual misconduct event is entered into the internal incident reporting system. The Director of RM will run monthly reports to ensure all allegations of sexual misconduct are reported to the governing board at the PAC. Daily Review of the Nursing Supervisor report by the Director of RM will ensure that all allegations of sexual misconduct are captured and reported appropriately. The Behavioral Health Charge Nurse will ensure that all staff present on the unit are the appropriate/ necessary staff for the shift. Staff not assigned to the unit will be not be allowed onto the floor unless performing assigned duties requiring their presence.	6/17/19 6/11/19 6/17/19

Cathy J. McClellan VP, Risk Mgmt; PI 6-17-19

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A 145	Continued From page 8 by law enforcement for analysis. Patient arranges to be transported to rape trauma center at [named] Hospital for evaluation as recommended by law enforcement. Review of Police Report of SP #1 documented on 11/07/2018 at 7:30 PM to 8:00 PM showed that officers responded to the hospital psych ward in reference to a female patient accusing a male employee of the hospital touching her against her will. Officers made contact with complainant who stated that one of the male employees touched her inappropriately in various places about her body. According to patient, the male employee (later to be known as Staff-A) came into her room and began a conversation with her, while he was eating his dinner. Sometime during the conversation, the employee approached her and caressed her breast. Patient then stated that employee took her hand and forcefully placed her hand on his penis. The employee left the room soon after. The patient then stated that the employee came back to the room approximately 15-20 minutes later and made another advance by kissing and caressing her breast then touching her inappropriately by placing his (wet/saliva) hand on her vagina. The employee allegedly took a picture of the patient while she was getting dressed before leaving the room. Officers made contact with the employee who admitted to having a conversation with the patient, but denied any physical contact with the female. Review of Staff-A clock punches documented on 11/01/2018 to 11/30/2018 that employee worked Wednesday, 11/07/2018, (date of incident) and returned to regular work schedule on Friday, 11/09/2018 to 05/22/2019 prior to the DNA results.	A 145	Continued from Page 8 An education was provided to clinical staff clarifying the process regarding allegations of abuse. The definition of sexual assault, their duty to report and how to handle these situations was also covered in the education. Nursing Admin held a huddle with Nursing Leaders to explain the process of reporting and what their role is when an allegation is brought to their attention. The Nursing Supervisor will assure that the proper documentation in the medical record reflects the date/time/follow up of the phone call made to report the incident. Nursing Supervisor will also document the reporting of the incident on the Nursing Supervisor Report, which will serve as a double-check for RM to follow up with. RM conducted an analysis of the event with staff from BH and reviewed the surveillance video. A summary of lessons learned will be disseminated to Behavioral Health staff, Nursing leadership and PAC. "Purposeful Rounding" education was conducted to re-educate staff on the appropriate protocol when conducting rounds or having interactions with patients. Longer conversations or 1:1 support will be done in the hallway or in an area where there is video surveillance. Staff who do not complete this education due to scheduling or leave cannot resume patient care until they have completed the course. **Quality Monitoring and Accountability for A-145 CFR(s): 482.13(c)(3) 1.)** BH created a monitoring log to validate Q15 checks. This monitoring will be accomplished by doing unannounced spot-check visual rounding and by monitoring the camera surveillance in the nursing station real-time. This will be done by Director of BH. 2.) Education compliance of the Sexual Abuse education will be 90% compliance as exhibited by the NetLearning electronic report by 6/17/19. Of those employees not scheduled during the roll-out of this education, all employees will complete the course before resuming patient care. This is done by the Manager of Training and Development. Evidence of compliance will be submitted to the PI department by 6/17/19. A weekly report will be submitted to the PI department to show evidence of completion for those employees who were not scheduled during the roll out of this education.	6/17/19 6/14/19 6/17/19

Cathy J. McClellan VP, Risk Mgmt & PI 6-17-19

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A 145	Continued From page 9 Review of 4 Warner Southeast Corridor (Female Wing) video footage of Staff-A and SP #1 on 06/04/2019 revealed that Staff-A entered and exited the room of SP #1 on 11/07/2018 at the following times: 1. Staff-A Entered: 7:04:40 PM, Staff-A Exited: 7:07:45 PM 2. Staff-A Entered: 7:08:23 PM, Staff-A Exited: 7:11:06 PM 3. Staff-A Entered: 7:12:47 PM, Staff-A Exited: 7:14:20 PM 4. SP #1 in hallway at 7:23:48 PM and returns to room at 7:26:04 PM 5. Staff-A in hallway speaking with SP #1 at 7:31:38 PM 6. SP #1 enters room at 7:31:44 PM and Staff-A follows, Staff-A Exited: 7:32:16 PM 7. SP #1 out of room at 7:32:22 PM and returns to room at 7:32:26 PM 8. Staff-A walks down the hallway and SP #1 follows at 7:33:20 PM 9. SP #1 enters room at 7:33:40 PM 10. Staff-A Entered: 7:33:47 PM, Staff-A Exited: 7:35:23 PM 11. Staff-A Entered: 7:35:27 PM, Staff-A Exited: 7:35:58 PM 12. SP #1 out of room at 7:37:00 speaks with employees and nursing station and returns to room at 7:41:35 PM 13. SP #1 observed in and out of room multiple times and pacing the hallway from at 7:42 PM to 7:55 PM 14. Police observed at 8:49:22 In an interview with Vice President Risk Management on 05/29/2019 at 11:07AM revealed on 11/05/2018, patient complained of being sexually assaulted by a Mental Health Technician (MHT) and identified employee by name. The	A 145	Continue from page 9 3.) Purposeful Rounding education will be documented by the Director of Behavioral Health. 100% compliance will be exhibited by sign-in sheet provided to the PI Department. 4.) Director of Risk Management will audit the reporting process outlined in policy for all allegations of sexual misconduct. This audit will assure that the appropriate 1:1 observation was assigned, that the accused employee was suspended/removed, DCF was called and the Police were notified. Four months of data will be submitted to the Quality Manager to show evidence of 100% compliance.	

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A 145	Continued From page 10 police were called and conducted an investigation. Arrangements were made to transfer patient with 2-MHT employees to the Rape Treatment Center to be evaluated. At some point, the police interviewed the employee and obtained DNA specimen from him. Investigation was conducted by Risk Management, Human Resources and the Behavioral Health Nursing Director, all whom spoke with employee. Employee indicated that he was in the room only minutes. Last Wednesday, 05/22/2019, the hospital administration was informed that the DNA sample taken from the patient matched the DNA taken from the employee and the employee was arrested. The following day, Thursday, 05/23/2019, the Vice President Risk Management and the Director Risk Management notified the Joint Commission but did not notify the Department of Children's and Families. The DNA findings were consistent with the police report, on the breast and the in the vagina. In an interview with Director Risk Management on 05/29/2019 at 12:15 PM revealed that the police stated the allegations were unfounded, patient had history of reporting allegations of the same nature and from their end employee was cleared until the results of the DNA testing. In an interview with (Primary Nurse) Staff-D via telephone on 05/29/2019 at 3:25 PM revealed that nurse was in the hallway when the patient was yelling and mentioned that the Spanish guy raped me. Nurse calmly approached patient and listened to the complaint. Nurse and patient talked and the patient gave the description that the mental health technician had entered the patient's room but did not go into detail about what had happened.	A 145		

Cathy J. McClellan VP, Risk Mgmt & PI 6-17-19

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A 145	Continued From page 11 Interview with (Charge Nurse) Staff-E via telephone on 5/29/2019 at 3:35PM revealed that the patient was by the room door complaining. The charge nurse notified the Clinical Director Behavioral Health whom instructed the charge nurse to call the police department. The employee was assigned to work in the emergency department psyche intake area and had brought 5 admissions from the emergency department to the behavioral health unit during the 3P-11P shift. The Behavioral Health policy with the title: "Victims of Abuse, Assault or Neglect, 16.4.008," (revised date: 05/2019) states that the department of psychiatry/behavioral health shall strive to identify, treat and report all cases of abuse, assault or neglect. This included, but is not limited to, adult and elder abuse and neglect, domestic violence, victims of crime and sexual molestation. Staff Education: 1. All staff in the department will receive initial and ongoing training in identifying possible victims of abuse, assault or neglect. 2. Any employee who knows, or has reasonable cause to suspect that an aged person or disabled adult is or has been abuses, abandoned, neglected, or exploited, shall immediately report such knowledge or suspicion to the Director. Director or designee must notify the Central Abuse Hotline of the Department of Children and Family Services via 1-800-96-ABUSE (1-800-962-2873). The Behavioral Health policy with the title: "Suspected Patient Abuse/Neglect, 16.4.021," (revised date: 05/2019) states all patients admitted to the Department of	A 145		

Cathy J. McClellan VP, RM & PI 6-17-19

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A 145	Continued From page 12 Psychiatry/Behavioral Health Unit shall be protected from abuse of any kind including physical roughness, verbal threats or harassment,. DEFINITION: SEXUAL ABUSE - Sexual abuse includes any sexual overture made to a patient verbal or physical irrespective of patient's willingness to be involved in it. The Behavioral Health policy title:d "Abuse Reporting: External and Internal Events, 16.4.015, (revised date: 06/2016) states that the incident shall be reported to the Abuse registry at 1-800-96-ABUSE immediately after the Chairman of the Department and/or Nurse Director are informed of the matter. Documentation in the patient's medical record shall include the time of call, supportive information, and any follow-up contact.	A 145	A-263 CFR(s): 482.21 Risk Management conducted an analysis of the event with staff from BH and reviewed the surveillance video. Further action above and beyond as described in this CAP will be developed. A summary of lessons learned will be disseminated to Behavioral Health staff, Nursing leadership and PAC. This event was self-reported to The Joint Commission.	6/13/19 5/23/19
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.	A 263	**Quality Monitoring and Accountability for A-263 CFR:482.21** 1. Director of Risk Management will audit the reporting process outlined in policy for all allegations of sexual misconduct. This audit will assure that the appropriate 1:1 observation was assigned, that the accused employee was suspended/removed, DCF was called and the Police were notified. Four months of data will be submitted to the Quality Manager to show evidence of 100% compliance. 2. Policies listed above were approved by PAC, uploaded to Policy Stat, rolled out to staff and changes were communicated via Policy Memo from the Chief Compliance Officer. 3. A Risk Management log was created to validate compliance of daily reporting. Director of RM will monitor Nursing Supervisor Report in order to complete the log on a daily basis. The log will include verification of the following: notification of the CEO by the VP of Risk Management, notifying DCF, notifying the Police and documentation of DCF notification in the medical record. 4.) VP of Risk will present Lessons Learned at PAC as a result of the RCA. 5.)Compliance of the New Employee education will be documented by the Manager of Training and Development. 100% compliance will be exhibited by signed check lists submitted to the Quality Manager. 6.) Compliance of the New Employee education will be documented by the Manager of Training and Development. 100% compliance will be exhibited by signed check lists submitted to the Quality Manager.	

Cathy McClellan VP, RM & PI 6-17-19

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A 263	Continued From page 13 This CONDITION is not met as evidenced by: Based on record review, staff interviews, and review of policies, the facility Quality Assessment and Performance Improvement Program failed to develop, identify opportunities for improvement and have an Action Plan aimed at performance improvement;and provide clear expectations for safety as a result of an incident of sexual assault involving a patient (SP #1) of 4 sampled patients (SP). (Refer to A-0283 and A-0286).	A 263	Continue from page 13 7.) Purposeful Rounding education will be documented by the Director of Behavioral Health. 100% compliance will be exhibited by sign-in sheet provided to the PI Department. A-283 CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) RM conducted an analysis of the event with staff from BH and reviewed the surveillance video. A summary of lessons learned will be disseminated to Behavioral Health staff, Nursing leadership and PAC. The Abuse and Neglect Policy was updated and now includes a checklist attached to guide Nursing Leaders on how to handle and report these allegations. The checklist describes how and when to contact RM. The BH	6/13/19
A 283	QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	A 283	Nursing Director conducts monthly environmental safety rounds through the unit. This data is presented to the Behavioral Health Patient Safety Committee and then presented at the Organization-wide Patient Safety Committee. The Behavioral Health Patient Safety Committee also debriefs and develops action plans for notable incidents occurring in the Behavioral Health units. Risk Management reviews all incidents that are reported in the Behavioral Health unit. Follow-up actions, as necessary, are tracked in the incident reporting system. Policy now states that video surveillance will be reviewed immediately following the report. **Quality Monitoring and Accountability A-283 CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3)** 1.) Policies listed above were approved by PAC, uploaded to Policy Stat, rolled out to staff and changes were communicated via Policy Memo from the Chief Compliance Officer. 2.) A Risk Management log was created to validate compliance of daily reporting. Director of RM will monitor Nursing Supervisor Report in order to complete the log on a daily basis. The log will include verification of the following: notification of the CEO by the VP of RM, notifying DCF, notifying the Police and documentation of DCF notification in the medical record. 3.) BH monitoring log to validate Q15 checks. This monitoring will be accomplished by doing unannounced spot-check visual rounding and by monitoring the camera surveillance in the nursing station real-time. This will be done by Director of BH.	6/17/19

Cathy + McClellan VP, RM; PI 6-17-19

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A 283	Continued From page 14 This STANDARD is not met as evidenced by: Based on record review, staff interviews, and review of policies the facility failed to fully implement the Quality Assessment and Performance Improvement Action Plan aimed at performance improvement as a result of an a sexual assault incident involving 1 (SP #1) of 4 sampled patients (SP). The findings include: The Census: on 11/07/2018, for the 3:00PM -11:00PM shift, was 21 patients with 8 females. Clinical Record review of sample patient (SP) #1, revealed she arrived in the ER (Emergency Room) on 11/05/2019 at 10:22 PM. She was Baker Acted on 11/06/2018 at 12:01PM for recurrent major depressive disorder/suicidal ideation. She was admitted to the Behavioral Health Unit on 11/06/2018 at 11:00 AM. Review of Behavioral Health Nursing Notes of the (Primary Nurse) Staff-D, documented on 11/07/2018 at 11:32 PM that at 7:40 PM patient approaches registered nurse on duty to complain that she has been sexually harassed by emergency room mental health technician in her room 474. Charge nurse and attending psychiatrist made aware. Police notified. Evidence collected by law enforcement for analysis. Patient arranges to be transported to rape trauma center at [named] Hospital for evaluation as recommended by law enforcement. In an interview with Vice President Risk Management on 05/29/2019 at 11:07AM revealed on 11/05/2018, patient complained of being	A 283	Continue from page 14 4.) VP of RM will present Lessons Learned at PAC as a result of the RCA. In addition, results of Quality Monitoring will be presented on a monthly basis until completion of the action plan. 5.) Education compliance of the BH General Safety Policy will be 100% compliance as exhibited through the sign-in sheet by 6/17/19. Evidence of compliance will be submitted to the PI department by June 17, 2019. A weekly report will be submitted to the PI department to show evidence of completion for those employees who were not scheduled during the roll out of this education. This was rolled out by the Director of BH. 6.) Education compliance of the Sexual Abuse education will be 90% compliance as exhibited by the NetLearning electronic report by 6/17/19. Of those employees not scheduled during the roll-out of this education, all employees will complete the course before resuming patient care. This is done by the Manager of Training and Development. Evidence of compliance will be submitted to the PI department by 6/17/19. A weekly report will be submitted to the PI department to show evidence of completion for those employees who were not scheduled during the roll out of this education. 7.) Compliance of the New Employee education will be documented by the Manager of Training and Development. 100% compliance will be exhibited by signed check lists submitted to the Quality Manager. 8.) Purposeful Rounding education will be documented by the Director of Behavioral Health. 100% compliance will be exhibited by sign-in sheet provided to the PI Department.	

Cathy McClellan VP, RM; PI 6-17-19

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A 283	Continued From page 15 sexually assaulted by a Mental Health Technician (MHT) and identified employee by name. The police were called and conducted an investigation. Arrangements were made to transfer patient with 2-MHT employees to the Rape Treatment Center to be evaluated. At some point, the police interviewed the employee and obtained DNA specimen from him. Investigation was conducted by Risk Management, Human Resources and the Behavioral Health Nursing Director, all whom spoke with employee.. Employee indicated that he was in the room only minutes. Last Wednesday, 05/22/2019, the hospital administration was informed that the DNA sample taken from the patient matched the DNA taken from the employee and the employee was arrested. The following day, Thursday, 05/23/2019, the Vice President Risk Management and the Director Risk Management notified the Joint Commission but did not notify the Department of Children's and Families. The DNA findings were consistent with the police report, on the breast and the in the vagina. The actual results were not provided to the facility. Interview with Clinical Director Behavioral Health on 05/29/2019 at 3:02PM revealed the employee Staff A attended a 1-day training on 05/22/2019 and went to police station. This was the last day of work for the employee. The Clinical Director Behavioral Health had a staff meeting on 11/15/2018, to discuss mandatory education on abuse and neglect and remind staff about not entering patient rooms alone. Review of Behavioral Health General Staff Meeting Agenda documented on 11/15/2018 revealed Findings/Conclusions: Only enter patient room alone when doing rounds or quickly completing duties/tasks. Do not have 1:1 conversations alone	A 283		

Cathy J. McClellan VP, RN; PI 6-17-19

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A 283	Continued From page 16 in room, this is regardless of gender. This is the best way to protect yourself from allegations and possible physical violence. Recommendations/Action: Longer conversations or 1:1 support should be given in hallway or dining rooms (anywhere on camera). Any longer activity, get second staff. No students or Non-behavioral health staff to be left alone with patients. Accompany them to rooms. Review of Department of Psychiatry/Behavioral Health Sign-in sheet revealed approximately 51 signatures out of approximately 86 staff members in attendance. No policy was written or corrective action plan was implemented after the incident. The Policy titled: "Sentinel Events and Significant Occurrences, 1.28.026," (revised date: 06/2018) states that sexual abuse/assault including "rape" is defined as nonconsensual sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal or anal penetration or fondling of the patients sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present to determine that it is a sentinel event: Any staff witnessed sexual contact as described above, sufficient clinical evidence obtained by the hospital to support allegations of unconsented sexual contact or admission by the perpetrator that sexual contact, as described above, occurred on the premises. A thorough and credible Root Cause Analysis will be conducted for any Sentinel Event as defined in this policy. The hospital disseminates lessons learned from root cause analyses, system or process failures to all staff who provide services for the specific situation.	A 283		

Cathy J. McClellan VP, RM & PI 6-17-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100034	A. BUILDING _____ B. WING _____	C 06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT SINAI MEDICAL CENTER	4300 ALTON RD MIAMI BEACH, FL 33140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 286	Continued From page 17	A 286	A-286 CFR(s): 482.21(a), (c)(2), (e)(3)	
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on record review, staff interviews, and review of policies, the facility governing body failed to assume responsibility in setting clear expectations for safety as a result of an incident of sexual assault involving a patient (SP #1) of 4 sampled patients (SP). The findings include: Clinical Record review of sample patient (SP) #1,	A 286	Risk Management conducted an analysis of the event with staff from BH and reviewed the surveillance video. Further action above and beyond as described in this CAP will be developed. A summary of lessons learned will be disseminated to Behavioral Health staff, Nursing leadership and PAC. Quality Monitoring as a result of this analysis will be rolled out and shared as described above. The Abuse and Neglect Policy was updated and now includes a checklist attached to guide Nursing Leaders on how to handle and report these allegations. The checklist describes how and when to contact Risk Management. The Behavioral Health Nursing Director conducts monthly environmental safety rounds through the unit. This data is presented to the Behavioral Health Patient Safety Committee and then presented at the Organization-wide Patient Safety Committee. The Behavioral Health Patient Safety Committee also debriefs and develops action plans for notable incidents occurring in the Behavioral Health units. An education titled "Purposeful Rounding" was conducted to re-educate staff on the appropriate protocol when conducting rounds or having interactions with patients. Longer conversations or 1:1 support will be done in the hallway or in an area where there is video surveillance. Staff who do not complete this education due to scheduling or leave cannot resume patient care until they have completed the course. **Quality Monitoring and Accountability for A-286 CFR(s): 482.21(a), (c)(2), (e)(3)** 1.) Policies listed above were approved by PAC, uploaded to Policy Stat, rolled out to staff and changes were communicated via Policy Memo from the Chief Compliance Officer. 2.) A Risk Management log was created to validate compliance of daily reporting. Director of RM will monitor Nursing Supervisor Report in order to complete the log on a daily basis.	6/13/19 6/17/19 6/17/19 6/17/19

Cathy J. McCullen VP, Risk Mgmt & PI 6-17-19

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A 286	Continued From page 18 revealed she arrived in the ER (Emergency Room) on 11/05/2019 at 10:22 PM. She was Baker Acted on 11/06/2018 at 12:01PM for recurrent major depressive disorder/suicidal ideation. She was admitted to the Behavioral Health Unit on 11/06/2018 at 11:00 AM. Review of Behavioral Health Nursing Notes of the (Primary Nurse) Staff-D, documented on 11/07/2018 at 11:32 PM that at 7:40 PM patient approaches registered nurse on duty to complain that she has been sexually harassed by emergency room mental health technician in her room 474. Charge nurse and attending psychiatrist made aware. Police notified. Evidence collected by law enforcement for analysis. Patient arranges to be transported to rape trauma center at [named] Hospital for evaluation as recommended by law enforcement. In an interview with Vice President Risk Management on 05/29/2019 at 11:07AM revealed on 11/05/2018, patient complained of being sexually assaulted by a Mental Health Technician (MHT) and identified employee by name. The police were called and conducted an investigation. Arrangements were made to transfer patient with 2-MHT employees to the Rape Treatment Center to be evaluated. At some point, the police interviewed the employee and obtained DNA specimen from him. Investigation was conducted by Risk Management, Human Resources and the Behavioral Health Nursing Director, all whom spoke with employee.. Employee indicated that he was in the room only minutes. Last Wednesday, 05/22/2019, the hospital administration was informed that the DNA sample taken from the patient matched the DNA taken from the employee and the employee	A 286	Continue from page 18 The log will include verification of the following: notification of the CEO by the VP of RM, notifying DCF, notifying the Police and documentation of DCF notification in the medical record. 3.) BH monitoring log to validate Q15 checks. This monitoring will be accomplished by doing unannounced spot-check visual rounding and by monitoring the camera surveillance in the nursing station real-time. This will be done by Director of BH. 4.) VP of RM will present Lessons Learned at PAC as a result of the RCA. In addition, results of Quality Monitoring will be presented on a monthly basis until completion of the action plan. 5.) Education compliance of the BH General Safety Policy will be 100% compliance as exhibited through the sign-in sheet by 6/17/19. Evidence of compliance will be submitted to the PI department by June 17, 2019. A weekly report will be submitted to the PI department to show evidence of completion for those employees who were not scheduled during the roll out of this education. This was rolled out by the Director of BH. 6.) Education compliance of the Sexual Abuse education will be 90% compliance as exhibited by the NetLearning electronic report by 6/17/19. Of those employees not scheduled during the roll-out of this education, all employees will complete the course before resuming patient care. This is done by the Manager of Training and Development. Evidence of compliance will be submitted to the PI department by 6/17/19. A weekly report will be submitted to the PI department to show evidence of completion for those employees who were not scheduled during the roll out of this education. 7.) Compliance of the New Employee education will be documented by the Manager of Training and Development. 100% compliance will be exhibited by signed check lists submitted to the Quality Manager. 8.) Purposeful Rounding education will be documented by the Director of Behavioral Health. 100% compliance will be exhibited by sign-in sheet provided to the PI Department.	

Cathy J. McClellan VP, Risk Mgmt & PI 6-17-19

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A 286	Continued From page 19 was arrested. The following day, Thursday, 05/23/2019, the Vice President Risk Management and the Director Risk Management notified the Joint Commission but did not notify the Department of Children's and Families. The DNA findings were consistent with the police report, on the breast and the in the vagina. The actual results were not provided to the facility. Interview with Clinical Director Behavioral Health on 05/29/2019 at 3:02PM revealed the employee Staff A attended a 1-day training on 05/22/2019 and went to police station. This was the last day of work for the employee. The Clinical Director Behavioral Health had a staff meeting on 11/15/2018, to discuss mandatory education on abuse and neglect and remind staff about not entering patient rooms alone. Review of Behavioral Health General Staff Meeting Agenda documented on 11/15/2018 revealed Findings/Conclusions: Only enter patient room alone when doing rounds or quickly completing duties/tasks. Do not have 1:1 conversations alone in room, this is regardless of gender. This is the best way to protect yourself from allegations and possible physical violence. Recommendations/Action: Longer conversations or 1:1 support should be given in hallway or dining rooms (anywhere on camera). Any longer activity, get second staff. No students or Non-behavioral health staff to be left alone with patients. Accompany them to rooms. Review of Department of Psychiatry/Behavioral Health Sign-in sheet revealed approximately 51 signatures out of approximately 86 staff members in attendance. No policy was written or corrective action plan was implemented after the incident. The Policy titled: "Sentinel Events and Significant	A 286		

Cathy J. McClellan VP, Risk Mgmt & PI 6-17-19

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A 286	Continued From page 20 Occurrences, 1.28.026," (revised date: 06/2018) states that sexual abuse/assault including "rape" is defined as nonconsensual sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal or anal penetration or fondling of the patients sex organ(s) by another individual's hand, sex organ or object. One or more of the following must be present to determine that it is a sentinel event: Any staff witnessed sexual contact as described above, sufficient clinical evidence obtained by the hospital to support allegations of unconsented sexual contact or admission by the perpetrator that sexual contact, as described above, occurred on the premises. A thorough and credible Root Cause Analysis will be conducted for any Sentinel Event as defined in this policy. The hospital disseminates lessons learned from root cause analyses, system or process failures to all staff who provide services for the specific situation.	A 286		

Cathy J. McClellan VP, RM & PI 6-17-19